



LEAVE NOTICE FOR BENEFIT
STATE FORM 50677 (R / 2-02)

Agency Instructions: This form must be completed for an employee who is going on unpaid leave. Send the notice to the carrier(s) as soon as possible and the carrier will bill the employee directly for insurance premiums while the employee is on leave. Date and sign the form below.

Benefit Carrier Instructions: It is important that the agency be notified when the employee pays the employee's portion of the premium for Family Medical Leave and Workers' Compensation. This will alert the agency to make the employer's payment of the premium at the appropriate time.

Agency Information (Please Print)

Agency Name _____ Benefits Coordinator _____

Agency Address _____ City _____ State / Zip _____ Phone Number _____

Employee Information (Please Print)

Employee Name _____ SSN _____

Employee Address _____ City _____ State / Zip _____

Type of Leave

____ Military Leave ____ Leave of Absence ____ Family / Medical Leave ____ Workers Compensation

Type of Coverage

Health: Single____ Family____ Provider: _____
Dental: Single____ Family____ Provider: _____
Vision: Single____ Family____ Provider: _____
Life: Basic____ Supp____ Dep____ Provider: _____

Pay Periods on Leave

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature _____ Date _____